U.S. Department of Labor

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Issue Date: 23 May 2003

CASE NO. 2002-BLA-278

In the Matter of:

DONALD VARNEY,
Claimant,

v.

BIG LUMP COAL CO.,
Employer,

and

TRAVELERS INSURANCE CO.,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-interest

Appearances: Susie Davis,
For Claimant

Lois A. Kitts, Esq.
For Employer/Carrier

Before: STEPHEN L. PURCELL
Administrative Law Judge

DECISION AND ORDER - DENYING MODIFICATION

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 *et seq*. On October 2, 2002, after proper notice to the parties, a hearing was held in Pikeville, Kentucky. Director's exhibits one through thirty-one, Claimant's exhibits one through

three, and Employer's exhibits one through six were admitted into evidence at the hearing.[1] The Employer filed a post-hearing deposition with three attached exhibits. The Claimant did not object to this exhibit and it is hereby admitted as EX7.[2] No representative for the Director, OWCP appeared at the hearing. Only the Employer submitted a post-hearing brief. This decision is based upon an analysis of the record, the arguments of the parties, and the applicable law.

The Department of Labor has issued regulations governing the adjudication of claims for benefits arising under the Black Lung Benefits Act at Title 20 of the Code of Federal Regulations. "[T]he procedures to be followed and standards applied in filing, processing, adjudicating, and paying claims" are set forth at 20 C.F.R., Part 725,[3] while the standards for determining whether a coal miner is totally disabled due to pneumoconiosis are set forth at 20 C.F.R., Part 718. Because the Miner's last coal mine employment occurred with Mullins Coal Company in Indiana (Tr. at 18,[4] DX2, DX5), the precedent of the U.S. Court of Appeals for the Seventh Circuit applies. *See Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

Background and History

Mr. Donald Varney ("Claimant") initially filed a claim for federal black lung benefits on March 20, 1990 (DX29). The District Director identified Big Lump Coal Company ("Big Lump" or "Employer") as the putative responsible operator and denied the claim on July 17, 1990. The District Director informed Claimant that he could submit further evidence or request a formal hearing within sixty days, otherwise the claim would be considered abandoned. The Claimant took no further action until filing the present claim.

The present claim was received on June 19, 2000 (DX1). The District Director again identified Employer as the responsible operator (DX11-12), which Employer contested (DX13). The claim was adjudicated as a duplicate claim pursuant to 20 C.F.R. § 725.309, which governs claims filed more than one year after a prior denial. The District Director denied benefits on

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[1] Exhibits submitted by the respective parties are indicated hereinafter as: "DX" for Director's exhibits, "EX" for Employer's exhibits, and "CX" for Claimant's exhibits.

[2] EX7 consists of four sub-exhibits: Dr. Fino's deposition, (EX7A), his curriculum vitae and certifications, (EX7B), his March 16, 2002 report, (EX7C), and his August 29, 2002 consultative report (EX7D).

[3] The U.S. Department of Labor revised the Part 725 regulations effective January 19, 2001. Because this claim was pending on January 19, 2001, certain sections of Part 725 from the edition revised as of April 1, 1999, apply. *See* 20 C.F.R. § 725.2(c) (2002). Otherwise, the revised regulations apply.

[4] References to the transcript of the October 2, 2002 hearing are noted as "Tr. at __" with the applicable page number inserted in the blank space.

October 6, 2000, based on Claimant's failure to establish a material change in condition in that he failed to show: he suffered from pneumoconiosis; that the disease, if it existed, was caused by coal mine employment; or that he was totally disabled by the disease (DX14). Claimant was thereafter informed that he could submit additional evidence or request a formal hearing within sixty days. The claim was deemed abandoned and administratively closed on January 23, 2001 when no further evidence was submitted (DX18).

Additional medical evidence was submitted by Claimant on September 28, 2001 (DX19), which the District Director deemed to be a request for modification (DX20). Modification was denied on December 18, 2001 because the additional evidence failed to establish a change in condition or mistake in a finding of fact as required by 20 C.F.R. § 725.310 (DX24). The Claimant requested a formal hearing on December 28, 2001 (DX25). The Employer filed an operator controversion form on January 29, 2002 (DX27).

Claimant was born August 9, 1935, has a 12th grade education, was married for 18 years but is now divorced, and has no dependants (DX1, Tr. 14-15, 29, 50). He testified he worked in coal mines for about twenty or twenty-one years and performed a variety of jobs including repairing and overhauling mining equipment, working as a hand-loader, and performing general maintenance (Tr.16-18, 28, 30, 38). He last worked in the coal mines in 1980 or 1981, and he has not been exposed to coal dust since then (Tr. 49). Claimant began smoking cigarettes when he was sixteen, smoked a pack per day when he was young but cut back to half a pack per day sometime later, and he is now only smoking three or four cigarettes daily (Tr. 25, 46-47). He is treated by Drs. Sundaram and Trivett, but only Dr. Sundaram treats him for his breathing problems (Tr. 25. 47). Dr. Sundaram prescribed oxygen for the Miner's breathing problems about a year and a half ago (Tr. 48). Claimant is currently receiving $565.00 monthly in Social Security disability benefits (Tr. 30).

Issues Presented

The contested issues are:

1. Whether the claim was timely filed.
2. Length of coal mine employment.
3. Whether Claimant has pneumoconiosis
4. Whether pneumoconiosis was caused by coal mine employment.
5. Whether Claimant is totally disabled.
6. Whether Employer is the responsible operator.
7. Whether the evidence establishes a material change in condition or a mistake in a determination of fact from the previously denied claim.
8. Whether Claimant's most recent period of cumulative employment of not less than one year was with the Employer.
9. Whether the revised regulations are constitutional.

The Employer's challenge to the constitutionality of the regulations is not properly raised at this level, but is preserved for appeal.

The issue of whether Claimant's most recent year of employment was with the Employer is subsumed by the issue of whether Employer was properly designated as the responsible operator. Both are addressed following the discussion of Claimant's length of coal mine employment.

Elements of Entitlement

The Black Lung Benefits Act, through its implementing regulations, provides benefits to miners who are totally disabled due to pneumoconiosis. *See* 20 C.F.R. § 718.204. Claimants must establish by a preponderance of the evidence the existence of pneumoconiosis, the relationship of pneumoconiosis to coal mine employment, and total disability caused by pneumoconiosis. *See* 20 C.F.R. §§ 718.202-718.204.

Because this is a request for modification, Claimant must show either that his physical condition has changed or that the District Director made a factual mistake in denying benefits on October 6, 2000. The United States Supreme Court, in *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971), indicated that all evidence of record should be reviewed in determining whether "a mistake in a determination of fact" was made. The Court further noted that the fact-finder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *Id*. This requires an independent assessment of the newly submitted evidence considered in conjunction with the previously submitted evidence to determine whether the weight of the evidence is sufficient to satisfy an element of entitlement which was previously adjudicated. *See Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994).

Medical Evidence

The following types of medical evidence may establish the existence of pneumoconiosis: chest x-ray, biopsy, autopsy, or a physician's medical opinion based on objective medical evidence such as blood-gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical exams, and medical and work histories. Likewise, pulmonary function tests, arterial blood-gas tests, evidence of cor pulmonale with right-sided congestive heart failure, or a physician's medical opinion based on medically acceptable clinical and laboratory diagnostic techniques may establish a claimant's total disability.

Chest X-Rays[5]

X-ray Date	Reading Date	Physician	Qualifications	Film Quality	Findings	Exhibit
04/09/90	04/09/90	Poulos	BCR, B-reader	1	Film is completely negative	DX29
04/09/90	05/02/90	Sargent	BCR, B-reader	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis	DX29
04/09/90	05/03/90	Gordonson	BCR, B-reader	2	No parenchymal or pleural abnormalities consistent with pneumoconiosis	DX29
07/18/00	07/18/00	Sundaram	Board certified pulmonologist	–	Lungs compatible with ILO pneumoconiosis, type p/s, profusion 2/2, upper and mid zones; no large opacities	DX8
07/18/00	08/18/00	Sargent	BCR, B-reader	2	Film is completely negative	DX10
07/18/00	05/16/02	Poulos	BCR, B-reader	2	Film is completely negative	EX4
12/20/00	01/13/01	Sundaram	Board certified pulmonologist	1	Parenchymal abnormalities consistent with pneumoconiosis; small opacities shape q/t, upper and mid zones, profusion 2/2; no large opacities; possible nodule right lower lobe	DX19, CX3
12/22/00	10/10/01	Barrett	BCR, B-reader	1	Film is completely negative	DX21
12/22/00	–	Potter	–	1	Parenchymal abnormalities consistent with pneumoconiosis; small opacities shape q/t, all zones, profusion 1/1; no large opacities	DX19, CX3
02/21/02	03/16/02	Fino	BCR, B-reader	1	Film is completely negative	EX7C
02/21/02	05/24/02	Wiot	BCR, B-reader	1	No parenchymal or pleural abnormalities consistent with pneumoconiosis	EX2
08/06/02	08/06/02	Narra	–	1	Parenchymal abnormalities consistent with pneumoconiosis; small opacities p/p, all zones, profusion 1/1; no large opacities	CX2, CX3

[5] The profusion (quantity) of the opacities (opaque spots) throughout the lungs is measured by four categories: 0 = small opacities are absent or so few they do not reach a category 1; 1 = small opacities definitely present but few in number; 2 = small opacities numerous but normal lung markings are still visible; and, 3 = small opacities very numerous and normal lung markings are usually partly or totally obscured. An interpretation of category 1, 2, or 3 means there are opacities in the lung which may be used as evidence of pneumoconiosis. If the interpretation is 0, then the assessment is not evidence of pneumoconiosis. A physician will usually list the interpretation with two digits. The first digit is the final assessment; the second digit represents the category that the doctor also seriously considered. For example, a reading of 1/2 means the doctor's final determination is category 1 opacities but he considered placing the interpretation in category 2. Similarly, a reading of 0/0 means the doctor found no opacities and did not see any marks that would cause him or her to seriously consider category 1.

X-ray Date	Reading Date	Physician	Qualifications	Film Quality	Findings	Exhibit
08/06/02	08/08/02	Sundaram	Board certified pulmonologist	–	Parenchymal abnormalities consistent with pneumoconiosis; small opacities shape p/q, upper and mid zones, profusion 2/2; no large opacities	CX1, CX3
08/28/02	08/28/02	Poulos	BCR, B-reader	1	Film is completely negative	EX6

Pulmonary Function Tests[6]

The Claimant's recorded height, which varies from sixty-six to sixty-eight inches, must be resolved. *See Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). I find Claimant's height to be sixty-seven inches because it is the median of the various values noted and was recorded on two occasions by Dr. Sundaram, Claimant's treating physician.

Date	Physician	Age	Height	FEV_1	FVC	MVV	FEV_1/ FVC	Pre/ Post	Notes	Exhibit
04/09/90	Mettu	51	68	2.60 (1.96)	3.24 (2.47)	50 (78)	80% (55%)	Pre	Good cooperation & understand-ing	DX29
07/18/00	Sundaram	61	67	1.57 (1.79)	2.34 (2.29)	34 (72)	67% (55%)	Pre	Good cooperation; invalidated by Dr. N.K. Burki because curve shapes indicate poor effort (DX9)	DX8
07/18/00	Sundaram	61	67	1.85 (1.79)	2.30 (2.29)	38 (72)	80% (55%)	Post	Good cooperation; invalidated by Dr. Burki (DX9)	DX8
02/28/01	Sundaram	62	67	1.24 (1.78)	1.59 (2.28)	40 (71)	78% (55%)	–	Invalidated by Drs. Maan Younes and N.K. Burki for insufficient tracings without explanation (DX22)	DX19, CX3
02/21/02	Fino	63	66	2.07 (1.76)	2.70 (2.26)	–	77% (55%)	–	Questionable effort, incomplete exhalation	EX7C
08/28/02	Rosenberg	64	66	2.19	3.03	74	72%	Pre	Good	EX6

[6] The qualifying disability pulmonary function values, as found at Part 718, Appendix B, are listed in parentheses.

Date	Physician	Age	Height	FEV_1	FVC	MVV	FEV_1/ FVC	Pre/ Post	Notes	Exhibit
				(1.75)	(2.24)	(70)	(55%)		cooperation & understanding	
08/28/02	Rosenberg	64	66	2.23 (1.75)	3.09 (2.24)	53 (70)	72% (55%)	Post	Good cooperation & understanding	EX6

Arterial Blood-Gas Tests[7]

Date	Physician	pCO2	pO2	Rest/Exercise	Exhibit
04/09/90	Mettu	35.9	74.8 (64)	Rest	DX29
07/18/00	Sundaram	39	81.2 (61)	Rest	DX8
07/18/00	Sundaram	36	86.5 (64)	Exercise	DX8
02/21/02	Wiot	38	73.6 (62)	–	EX7C
08/28/02	Rosenberg	36.6	76.2 (63)	–	EX6

Medical Opinion Evidence

Dr. Ramanarao V. Mettu examined Claimant on April 9, 1990 in connection with his claim for federal black lung benefits (DX29). The Claimant complained of daily mucoid expectoration for fifteen years, intermittent wheezing for five years, and exertional shortness of breath for three years. Dr. Mettu noted a history of hypertension, arthritis, smoking cigarettes for nearly thirty-seven years (only two cigarettes per day at that time), and sixteen years working in coal mines. Dr. Mettu reviewed three chest x-ray interpretations and administered an electrocardiogram, arterial blood-gas test, and pulmonary function test. The chest x-rays did not reveal any evidence of pneumoconiosis. Dr. Mettu diagnosed a mild pulmonary impairment.

Dr. R. Sundaram examined Claimant on July 18, 2000 in connection with his duplicate claim (DX8). The Claimant reported frequent colds, arthritis, hospitalization in 1973 for kidney problems, and daily occurrences of sputum production, wheezing, coughing, and paroxysmal nocturnal dyspnea. The Claimant also complained of dyspnea and chest pain on walking one-half of a city block. Dr. Sundaram noted that Claimant smoked cigarettes since the 1950's, currently smoked one-half pack of cigarettes per day, and worked for more than twenty years in coal mines. Dr. Sundaram administered a chest x-ray, pulmonary function test, and arterial blood-gas test. He interpreted the x-ray as compatible with ILO pneumoconiosis and the pulmonary function test as indicating qualifying disability values. Dr. Sundaram diagnosed arthritis and coal workers' pneumoconiosis ("CWP") due to prolonged exposure to coal dust, which contributed "51-100%" to his "class 4" impairment. On a separate form, Dr. Sundaram added that Claimant was totally disabled, that such impairment was related to CWP, but that it was difficult to attribute the amount of impairment due to coal dust versus that due to cigarette smoking. He concluded that

[7] The qualifying disability blood-gas values, as found at Part 718, Appendix C, are listed in parentheses.

Claimant did not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment due to his shortness of breath on limited activity.

Dr. Nolan Sakow administered a CT scan on January 17, 2001. Dr. Sakow reported: unremarkable pulmonary parenchyma; no evidence of any infiltrates, effusions, pneumothorax, or nodules; a mild right posterior pleural thickening of no clinical significance; the usual interstitial pattern; unremarkable pulmonary vessels; well aerated trachea and bronchi; normal heart size; normal enhancement of the large vessels; coronary calcifications; and no evidence of any mediastinal adenopathy (DX19). Dr. Sakow found this to be a "normal CT scan of the chest."

Dr. Sundaram examined Claimant again on February 28, 2001 and administered a pulmonary function test[8] (DX19, CX3). The Claimant reported over twenty years of coal dust exposure, increasing shortness of breath on walking one block or going up one flight of steps, smoking one-half pack of cigarettes per day, and an inability to bend, stoop, or work at unprotected heights. Dr. Sundaram and Dr. Ira Potter interpreted a chest x-ray taken December 22, 2000 as positive for pneumoconiosis (DX19). Based on the chest x-ray, Dr. Sundaram diagnosed CWP due to prolonged exposure to coal dust. He opined that Claimant was unable to do his usual coal mine employment due to his shortness of breath with limited activity and pulmonary function below fifty-five percent of the predicted result.

Dr. Gregory J. Fino examined Claimant on February 21, 2002 (EX7C). The Claimant reported smoking one-half pack of cigarettes since 1950 and that he was still smoking. He further stated that he had twenty-eight years of underground coal mine employment and complained of shortness of breath for thirty years. Dr. Fino noted a history of circulation problems, high cholesterol, breathing problems, kidney problems, colds, headaches, arthritis, and chronic sinus problems. A chest x-ray revealed no pleural or parenchymal abnormalities consistent with pneumoconiosis, which was confirmed by a CT scan performed the same day. Dr. Fino also administered pulmonary function and arterial blood-gas tests, which he interpreted as normal, but noted a reduced diffusing capacity secondary to active cigarette smoking. He concluded that the chest x-ray and CT scan evidence were negative for pneumoconiosis and that Claimant's pulmonary system was normal from a functional standpoint.

In a consultative report issued August 29, 2002, Dr. Fino reviewed Dr. Mettu's 1990 report, Dr. Sundaram's July 2000 and February 2001 reports, and the December 2000 chest x-rays of Drs. Sundaram, Barrett, and Potter (EX7D). Regarding the 1990 report of Dr. Mettu, he noted that no chest x-rays substantiated the existence of pneumoconiosis and that Dr. Mettu's pulmonary function study was nonconforming according to the accepted standards of the American Thoracic Society and American College of Chest Physicians because no tracings were provided. He repeated Dr. Mettu's observation that decreases in PO2 and FVC were "most

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[8] As noted in the pulmonary function test results section above, Drs. Younes and Burki invalidated this test because of insufficient tracings. The machine-printed report states, "MVV low relative to FEV1 suggests poor initial effort and/or neuromuscular disorder."

likely" due to exogenous obesity. Regarding the July 2000 report, he noted that Dr. Sargent interpreted the July 2000 x-ray as negative for pneumoconiosis but that Dr. Sundaram found pneumoconiosis with a profusion of 2/2. He repeated Dr. Sundaram's acknowledgment that it was difficult to separate the impairment caused by coal dust exposure from that caused by cigarette smoking. He found Dr. Sundaram's July 2000 pulmonary function study invalid because of "a premature termination to exhalation[,] a lack of reproducibility in the expiratory tracings[,] a lack of an abrupt onset to exhalation," and shallow and erratic individual breath volumes. Dr. Fino also noted that the July 2000 arterial blood-gas test revealed "no hypoxemia with exercise and no abnormal widening of the alveolar-arterial oxygen gradient," which indicated no pulmonary limitation to exercise. Dr. Fino noted that Drs. Sundaram and Potter interpreted the December 2000 chest x-ray as positive for pneumoconiosis, with profusions of 2/2 and 1/1 respectively, but that Dr. Barrett found no evidence of pneumoconiosis. Regarding Dr. Sundaram's February 2001 report, Dr. Fino again found the pulmonary function study invalid, this time because of a "premature termination to exhalation, lack of reproducibility, an abrupt onset to exhalation, and [erratic and shallow] individual breath volumes." He acknowledged Dr. Sundaram's finding of pneumoconiosis, with a profusion of 2/2. Upon reviewing all of this new evidence, Dr. Fino did not alter his earlier opinion that Claimant did not have pneumoconiosis or a totally disabling pulmonary impairment.

In an October 17, 2002 deposition, Dr. Fino explained that twenty-eight years of underground coal mine employment was sufficient for a susceptible individual to contract CWP, but that Claimant's history of smoking one-half pack of cigarettes since 1950 was also sufficient to cause a pulmonary problem (EX7A at 8). He noted that such a smoking history could cause chronic bronchitis, emphysema, shortness of breath, and lung cancer. He continued that Claimant had no lung abnormalities, such as rales, ronchi, or wheezes, that a lung disease would cause. Dr. Fino explained that neither the chest x-rays nor CT scans he reviewed exhibited changes consistent with CWP and opined that CT scans are much more sensitive for CWP than chest x-rays because CT scans take about thirty pictures of the chest (EX7A at 9-10). Dr. Fino explained that Claimant did not give the best effort on his pulmonary function test, which nevertheless exhibited no evidence of obstruction or restriction and normal diffusing capacity after correcting for Claimant's elevated carboxyhemoglobin due to active smoking (EX7A at 10-11). He noted the 1990 pulmonary function test, which was consistent with his findings, and the July 2000 and February 2001 pulmonary function tests, which were inconsistent but reflected poor effort (EX7A at 12). He also characterized the arterial blood-gas study as normal (EX7A at 12-13).

Dr. Wiot, a board-certified radiologist and B-reader, produced a medical report based on the Miner's chest x-ray and CT scan of February 21, 2002 (EX2). The chest x-ray indicated stranding in the right middle lobe, most likely of no clinical significance and unrelated to coal dust exposure, and no evidence of coal workers' pneumoconiosis. The CT scan indicated changes in the right middle lobe associated with pleural thickening, manifesting a past inflammatory process. Dr. Wiot believed this was also unrelated to coal dust exposure and found no evidence of coal workers' pneumoconiosis.

Dr. Rosenberg, who is a B-reader and board certified in internal medicine and pulmonary and occupational diseases, reviewed the previous chest x-rays, pulmonary function tests, arterial blood-gas tests, CT scan, and evaluation reports and personally evaluated Claimant on August 28, 2002 (EX6, TR. at 55-58). His report of the examination notes twenty-one years of coal mine employment and smoking one-half pack of cigarettes per day for over forty years. The physical exam revealed no distress and a congestive cough. He also administered a pulmonary function study, blood-gas test, EKG, and reviewed Dr. Poulos's chest x-ray. Dr. Rosenberg found that the chest x-ray did "not reveal the micronodular changes associated with past coal dust exposure [as] confirmed [by] the examination of his high-resolution CAT scan of the chest" and that Claimant's lung capacity and diffusing capacity (corrected for lung volumes) were normal (EX6 at 5). He stated that if micronodules were present, they would appear on the CT scan because it is a more sensitive instrument than an x-ray machine (Tr. at 70-74). He concluded that Claimant did not "have the interstitial form of coal workers' pneumoconiosis," had normal total lung capacity, and had a mildly reduced forced vital capacity due to air trapping and his excessive weight (EX6). He found that any mild obstruction present was related to Claimant's long and continued cigarette smoking.

Findings of Fact and Conclusions of Law

As stated above, a request for modification requires an independent assessment of the newly submitted evidence considered in conjunction with the previously submitted evidence to determine whether the weight of the evidence is sufficient to satisfy an element of entitlement which was previously adjudicated. *See Kingery v. Hunt Branch Coal Co.*, 19 B.L.R. 1-6 (1994). Accordingly, the District Director's October 2000 denial of benefits will not be modified unless the evidence establishes the presence of pneumoconiosis caused at least in part by coal mine work or that Claimant is totally disabled. The newly submitted medical evidence (i.e. that submitted after the District Director's October 6, 2000 denial) consists of nine chest x-ray interpretations, four pulmonary function tests, two blood-gas tests, Dr. Sakow's CT scan, and the reports of Drs. Sundaram, Fino, Wiot, and Rosenberg.

Timeliness of Filing

Although Employer previously checked a box on the operator controversion form indicating it was contesting the issue of whether the Miner's claim was timely, it does not explain on what basis it contests this issue and offers no evidence that the claim is untimely. A claimant may request reconsideration of a denial "at any time before one year after the denial of a claim." 20 C.F.R. § 725.310 (1999). Claimant requested modification of the October 6, 2000 denial on September 28, 2001 (DX20). Accordingly, I find that the claim was timely filed.

Length of Coal Mine Employment

The length of coal mine employment may trigger certain presumptions in 20 C.F.R., Part 718, Subpart D, and is relevant in determining whether a physician's opinion considered the proper amount of coal dust exposure. Employer and Claimant stipulated to at least seven years of coal mine employment at the hearing (Tr. at 52-53). Claimant testified that he worked for approximately twenty or twenty-one years in coal mines (Tr. at 28).

Claimant bears the burden of establishing the length of coal mine employment. *See Shelesky v. Director, OWCP*, 7 B.L.R. 1-34 (1984). The record contains copies of Social Security earnings statements dating from 1956, (DX5, 29), wage and tax statements dating from 1972, (DX6-7, 29), and pay records dating from 1977 (DX29). Claimant also states that he performed coal mine work for Daniels Coal Company from May 1956 to May 1958 and for Scotty Coal Company from May 1958 to June 1960 (DX2).

Coal mine employment may be established by any credible evidence, including company records, pension records, Social Security earnings records, co-worker affidavits, sworn testimony, the claim form, or other reasonable methods of calculation. *See Harkey v. Alabama By-Products Corp.*, 7 B.L.R. 1-26 (1984); *Clayton v. Pyro Mining Co.*, 7 B.L.R. 1-551 (1984). The regulations define one year of coal mine employment as "a period of one calendar year . . . , or partial periods totaling one year, during which the miner worked in or around a coal mine or mines for at least 125 'working days.'" 20 C.F.R. § 725.101(a)(32). To determine the number of days worked in a given year when the beginning and ending dates are not of record, the regulations provide the following formula: divide the miner's yearly income from work as a coal miner by the coal mine industry's average daily earnings for the given year as reported by the Bureau of Labor Statistics.[9] *See* 20 C.F.R. § 725.101(a)(32)(iii). The Bureau of Labor Statistics tracks the average hourly earnings, not average daily earnings, therefore I will assume that the average daily earnings equals eight hours multiplied by the average hourly earnings. Also, because Claimant has stated that his hourly income for Belfry Coal Company, where he worked in 1965-66, was $2 per hour, (Tr. at 33), I will use that figure rather than the BLS average. Similarly, because Claimant stated that his income from Loftis Coal Company, where he worked from 1970-76 and 1979, was $24 per shift, (Tr. at 37), I will assume that he was paid $24 per day. However, the Social Security records indicate that he worked only briefly for Loftis Coal Company in 1976 and 1979, so I will use the formula stated in the regulations for those years. Also, Claimant reported earning between $50 and $100 per shift from Employer in 1976-77. Due to Claimant's inability to provide a more definitive basis for calculating his wages while employed by Employer during this period, I find the Bureau of Labor Statistics' average income data is likely to provide a reliable basis for this calculation.

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[9] The Bureau of Labor Statistics tracks the average hourly earnings of employees in the coal mining industry, *available at* http://www.bls.gov/ces/cesnaics.htm (last visited May 15, 2003). For purposes of determining the average daily income, the average hourly income is multiplied by eight hours.

The table below sets forth Claimant's Social Security earnings, Claimant's reported income, the Bureau of Labor Statistics' average daily earnings, and the resulting calculations of estimated days worked pursuant to the regulatory formula.

Year	Claimant's Income From Coal Mine Operators	Claimant's Reported Daily Income	125 days at Claimant's Hourly Income	BLS Average Hourly Income	BLS Average Income For 125 Days
1957	$350.00			$2.90	$2,900.00
1963	$461.13			$3.12	$3,120.00
1965	$690.00	$16.00	$2,000.00		
1966	$384.00	$16.00	$2,000.00		
1967	$1,645.61			$3.73	$3,730.00
1968	$4,108.34			$3.83	$3,830.00
1970	$585.06	$24.00	$3,000.00		
1971	$7,937.50	$24.00	$3,000.00		
1972	$9,000.00	$24.00	$3,000.00		
1973	$10,800.00	$24.00	$3,000.00		
1974	$12,986.86	$24.00	$3,000.00		
1975	$14,100.00	$24.00	$3,000.00		
1976	$17,109.33			$7.74	$7,740.00
1977	$6,375.56			$8.25	$8,250.00
1978	$ 546.09			$9.51	$9,510.00
1979	$2,888.00			$10.28	$10,280.00
1980	$1,308.55			$10.86	$10,860.00

Claimant alleges that the Social Security earnings records are inaccurate because some operators for whom he worked did not report his wages (Tr. at 33-34). Claimant repeatedly stated, however, that he was unable to estimate how long he worked for each operator and did not remember working for others, despite detailed questioning regarding each employer listed on the Social Security earnings report (Tr. at 30-46). I find the Social Security earnings records provide the most reliable method for calculating Claimant's period of coal mine employment because they indicate earnings from employers dating back to 1956, Claimant's recollection regarding specific periods of employment and employers was vague, and he has provided no other evidence to substantiate his claim that he worked approximately twenty or twenty-one years in coal mining.

The Social Security earnings records reveal that, from 1957 through 1980 (the years in which Social Security earnings records indicate Claimant worked for coal mine operators), Claimant's income for 125 days was greater than the average income for coal miners in only seven of those years (i.e. 1968, 1970-75) (DX5, 29). Accordingly, I find that Claimant has established seven years of coal mine employment.

Designation of Employer as Responsible Operator

The operator that most recently employed Claimant for a period of at least one year (or partial periods of cumulative employment totaling at least one year) is responsible for federal black lung benefits. *See* 20 C.F.R. § 725.493(a)(1) (1999). The District Director designated Big Lump Coal Company as the responsible operator based on Claimant's allegations (DX11). A review of Claimant's Social Security earnings records indicates Claimant worked for Big Lump from the second quarter (July - September) of 1976 through the fourth quarter (October - December) of 1977 (DX5, 29). There are no other reported earnings from other employers in this time period. The records further indicate that Claimant worked for other coal mine operators at a later time,[10] but they do not establish that he worked a cumulative total of at least one year for any of those operators (DX5, 29). Employer has offered no argument how the District Director erred in designating it as the responsible operator, and I find Big Lump is properly designated as the responsible operator.

Existence of Pneumoconiosis

The presence of pneumoconiosis may be established by a chest x-ray, biopsy or autopsy, regulatory presumption, or physician's opinion based on objective medical evidence. *See* 20 C.F.R. § 718.202(a). There is no biopsy or autopsy evidence and the regulatory presumptions do not apply.[11]

Chest X-Rays

Where two or more x-ray reports are in conflict, "consideration shall be given to the radiological qualifications of the physicians interpreting such x-rays." 20 C.F.R. § 718.202(a)(1). A Board-certified radiologist is certified in radiology or diagnostic roentgenology by the American Board of Radiology or the American Osteopathic Association. Requirements for this

[10] Claimant also worked again for Big Lump Coal Company in 1978, earning $910.00 (DX4).

[11] The regulatory presumption at section 718.304 does not apply because none of the chest x-ray interpretations found the existence of "one or more large opacities (greater than 1 centimeter in diameter) . . . classified in Category A, B, or C." 20 C.F.R. § 718.304. The regulatory presumptions at sections 718.305 and 718.306 do not apply because this claim was filed after 1982. *See* 20 C.F.R. § 718.305(e), 20 C.F.R. § 718.306(a).

classification include four years of postgraduate training followed by successful completion of comprehensive written and oral examinations. A portion of the oral examination is devoted to testing the candidate's proficiency in diagnosing diseases of the lungs. *See Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211 (1985). A "B-reader" is a physician, but not necessarily a radiologist, who has demonstrated proficiency in classifying x-rays according to the ILO-U/C standards by successful completion of an examination established by the National Institute of Safety and Health. *See* 20 C.F.R. §718.202(a)(1)(ii)(E); 42 C.F.R. §37.51; *Roberts*, 8 B.L.R. 1-211. A physician possessing the dual qualifications of Board-certified radiologist and B-reader ("dually certified radiologist") is entitled to greater weight than physicians certified only as a radiologist or B-reader. *See Roberts*, 8 B.L.R. 1-211.

The previously submitted evidence consists of three interpretations of a chest x-ray taken on April 9, 1990 and two interpretations[12] of an x-ray taken July 18, 2000. Drs. Poulos, Sargent, and Gordonson, all dually certified radiologists, interpreted the April 9, 1990 chest x-ray as either completely negative or showing no parenchymal or pleural abnormalities consistent with pneumoconiosis (DX29). Dr. Sargent also interpreted the July 18, 2000 x-ray as completely negative, (DX10), but Dr. Sundaram found the lungs to be compatible with pneumoconiosis, profusion 2/2, in the upper and mid zones (DX10).

The newly submitted x-ray evidence consists of a third interpretation of the July 18, 2000 chest x-ray, and interpretations of chest x-rays taken December 20, 2000, December 22, 2000, February 21, 2002, August 6, 2002, and August 28, 2002.

Dr. Poulos provided the third evaluation of the July 18, 2000 x-ray, finding it completely negative (EX4). Dr. Poulos is a dually certified radiologist and I accord great weight to his interpretation.

Dr. Sundaram interpreted a chest x-ray taken December 20, 2000, as consistent with pneumoconiosis, numerous small opacities (i.e. profusion 2/2) in the upper and mid zones, and no large opacities (DX19, CX3). Dr. Sundaram's letterhead indicates that he is a pulmonary specialist, but no radiological qualifications are reported. I accord less weight to his interpretation because it conflicts with all the previous interpretations by dually qualified radiologists (Drs. Poulos, Sargent, and Gordonson), that found no evidence of pneumoconiosis. I also attribute less weight to this interpretation because it conflicts with the interpretations of Drs. Barrett, Fino, Wiot, and Poulos, who viewed subsequent chest x-rays, including one taken two days later, yet found no evidence of pneumoconiosis.

Dr. Barrett, who is dually qualified as a board certified radiologist and B-reader, interpreted the December 22, 2000 x-ray as completely negative (DX21). I attribute great weight to his interpretation because he is a dually qualified radiologist. Dr. Potter, whose qualifications

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[12] These two chest x-ray interpretations comprised the only x-ray evidence before the District Director in the Claimant's duplicate claim (DX14).

are not of record,[13] viewed the December 22, 2000 chest x-ray and found parenchymal abnormalities consistent with pneumoconiosis, a few small opacities throughout all zones, and no large opacities (DX19, CX3). I attribute less weight to Dr. Potter's finding because it is contradicted by Dr. Barrett, who is highly qualified to interpret chest x-rays for the presence of pneumoconiosis.

Drs. Fino and Wiot, who are both dually qualified as board certified radiologists and B-readers, interpreted the February 21, 2002 chest x-ray as negative. I accord great weight to their interpretations because of their superior qualifications, as well as the fact that their interpretations are consistent with the opinions of two other highly qualified physicians of record.

Dr. Narra, whose qualifications are not of record, viewed the August 6, 2002 chest x-ray and found parenchymal abnormalities consistent with pneumoconiosis, a few small opacities throughout all zones, and no large opacities (CX2, 3). Dr. Sundaram also interpreted this x-ray and found parenchymal abnormalities consistent with pneumoconiosis, numerous small opacities in the upper and mid zones, and no large opacities (CX1, 3). I accord little weight to these interpretations because neither physician possesses radiological qualifications and their results conflict with the interpretations of four dually qualified radiologists.

Lastly, Dr. Poulos interpreted the August 28, 2002 chest x-ray as completely negative (EX6). As noted above, Dr. Poulos is a dually qualified radiologist and I accord great weight to this interpretation.

Considered independently and in conjunction with the previous evidence, the newly submitted evidence does not establish the presence of pneumoconiosis.

Medical Opinions

The presence of pneumoconiosis may also be established by a physician's opinion based on objective medical evidence. *See* 20 C.F.R. § 718.202(a). Medical opinions must be documented and reasoned. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *See Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "reasoned" opinion is one in which the underlying documentation and data adequately support the physician's conclusions. *See id*. A physician's opinion may receive greater weight based on qualifications and ability to observe the claimant personally. *See e.g. Onderko v. Director, OWCP*, 14 B.L.R. 1-2 (1989). The medical opinion

[13] The party seeking to rely on an x-ray interpretation bears the burden of establishing the qualifications of the reader. *See Rankin v. Keystone Coal Mining Co.*, 8 B.L.R. 1-54 (1985).

evidence submitted prior to this modification request consists of Dr. Mettu's and Dr. Sundaram's medical reports.[14]

Dr. Mettu's April 1990 report was based on a physical examination, reported histories of 16 years of coal mine employment and 37 years of smoking cigarettes (only two cigarettes per day at that time), a chest x-ray, an electrocardiogram, an arterial blood-gas test, and a pulmonary function study (DX29). Based on the physical exam and pulmonary function study, Dr. Mettu diagnosed symptoms of chronic bronchitis, hypertension and arthritis by history, and exogenous obesity, none of which were attributed to Claimant's coal dust exposure. Dr. Mettu's letterhead indicates that he specializes in internal and pulmonary medicine.

Dr. Sundaram's July 2000 report found pneumoconiosis based on a physical examination, reported histories of more than twenty years coal mine employment and smoking cigarettes since the 1950's (currently one-half pack per day), a chest x-ray, a pulmonary function study, and an arterial blood-gas test (DX8). Dr. Sundaram diagnosed coal workers' pneumoconiosis due to prolonged exposure to coal dust based on Claimant's chest x-ray.

The newly submitted medical evidence includes five medical reports by Drs. Sundaram, Fino, Wiot, and Rosenberg.

Dr. Sundaram's February 28, 2001 medical report is based on a physical examination, a chest x-ray, a CT scan, and a pulmonary function test (DX19, CX3). The Claimant reported shortness of breath with limited activity, smoking one-half pack of cigarettes per day, and more than twenty years of coal dust exposure. Dr. Sundaram diagnosed coal workers' pneumoconiosis due to prolonged exposure to coal dust based on Claimant's chest x-ray and pulmonary function test. I accord little weight to this report because the basis for his conclusion is contradicted by more highly qualified physicians. Dr. Sundaram either expressed no knowledge of, or completely ignored, the numerous negative chest x-rays interpreted by the dually certified radiologists. Dr. Sundaram also either did not review, or completely ignored, Dr. Sakow's CT scan from one month earlier, which described: "unremarkable pulmonary parenchyma [and] no evidence of any infiltrates, effusions, pneumothorax, or nodules" (DX19). The only basis for his opinion is that the Claimant experienced a prolonged period of exposure to coal dust. The remaining medical opinions are based upon more reliable and objective medical evidence than the Claimant's exposure to coal dust.

Dr. Fino's opinion is based on a review of all of the medical opinions of the other physicians, as well as the Miner's history of twenty-eight years of coal dust exposure, cigarette smoking of one-half pack per day since the 1950's, and multiple chest x-rays, CT scans, pulmonary function studies, and arterial blood-gas tests which Dr. Fino either performed or reviewed (DX7A-D). He noted that twenty-eight years of underground coal mine employment

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[14] The only medical opinion evidence before the District Director consisted of Dr. Sundaram's July 18, 2000 report (DX14).

would be sufficient for a susceptible individual to contract pneumoconiosis but stated that Claimant's history of smoking one-half pack of cigarettes since 1950 would also be sufficient to cause pulmonary problems, such as chronic bronchitis, emphysema, shortness of breath, and lung cancer (EX7A at 8). Dr. Fino's physical examination revealed no lung abnormalities, such as rales, ronchi, or wheezes (EX7A at 8-9). He reviewed all of the available chest x-ray evidence, acknowledged Dr. Sundaram's and Dr. Potter's diagnoses of pneumoconiosis, (EX7D), but concluded that the chest x-ray evidence as a whole did not justify a diagnosis of pneumoconiosis (EX7A at 9-1, EX7C, D). I find this conclusion reasonable because Dr. Sundaram's and Dr. Potter's findings of pneumoconiosis are contradicted by the opinions of more highly qualified physicians. Dr. Fino explained that neither the chest x-rays nor CT scans exhibited changes consistent with CWP and stated that CT scans are much more sensitive for CWP than chest x-rays because CT scans take about thirty pictures of the chest (EX7A at 9-10). Dr. Fino also noted that the pulmonary function and arterial blood-gas tests of record were either invalid or normal and concluded that, from a functional standpoint, Claimant's pulmonary system is normal (EX7D). Dr. Fino's report is the most thoroughly documented of the all the medical reports and his conclusions are supported by objective medical evidence. I accord great weight to his opinion because he had an opportunity to personally examine Claimant, he reviewed all the relevant medical evidence of record, and he is a dually certified radiologist.

Dr. Wiot's opinion is based on his review of a February 21, 2002 chest x-ray and CT scan (EX2). The chest x-ray indicated stranding in the right middle lobe which was unrelated to coal dust exposure and most likely of no clinical significance. Dr. Wiot found the x-ray revealed no evidence of coal workers' pneumoconiosis. The CT scan indicated changes in the right middle lobe associated with pleural thickening, manifesting a past inflammatory process. Dr. Wiot believed this was also unrelated to coal dust exposure and found no evidence of coal workers' pneumoconiosis. Although based on more limited medical evidence than other physicians' opinions of record, Dr. Wiot's opinion is consistent with, and supported by, other substantial evidence of record, and I accord great weight to it because he is a dually certified radiologist.

Dr. Rosenberg's opinion is based on his evaluation of Claimant, a pulmonary function study, a blood-gas test, an EKG, a review of Dr. Poulos's August 2002 chest x-ray, as well as previous chest x-rays, pulmonary function tests, arterial blood-gas tests, a CT scan, and other medical reports (EX6). He noted twenty-one years of coal mine employment and smoking one-half pack of cigarettes per day for over forty years. His physical exam of the Miner revealed no distress and a congestive cough. The chest x-ray did "not reveal the micronodular changes associated with past coal dust exposure, confirmed by the CT scan performed in February 2001. Claimant's lung capacity and diffusing capacity were normal." Dr. Rosenberg's report sets forth much of the medical evidence of record, and his conclusion that Claimant did not have coal workers' pneumoconiosis is supported by chest x-rays and CT scans interpreted as negative for pneumoconiosis by the most highly qualified physicians. Dr. Rosenberg is board certified in pulmonary and occupational diseases and a B-reader. I accord great weight to his opinion because it is well documented and reasoned.

The newly submitted medical reports, except for that of Dr. Sundaram, found no evidence of pneumoconiosis. Dr. Sundaram's opinion is based upon chest x-ray interpretations and upon Claimant's prolonged exposure to coal dust. As noted above, I accord greater weight to the negative chest x-ray interpretations of physicians with greater radiological qualifications. I also find that the mere fact that Claimant was exposed to coal dust for a prolonged period of time is insufficient to negate the well documented and reasoned opinions of the highly qualified physicians who found no evidence of pneumoconiosis. This finding is supported by, and consistent with, the previously submitted evidence. Accordingly, I find that Claimant has failed to establish the presence of pneumoconiosis and deny modification of that finding.

Etiology of Pneumoconiosis

Once it is determined that the miner suffers from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). The District Director previously found that Claimant failed to satisfy this element (DX14). Because Claimant has failed to establish the presence of pneumoconiosis, consideration of this element is irrelevant. However, even if Claimant had established the presence of pneumoconiosis, the only evidence establishing a relationship between pneumoconiosis and coal mine employment is Dr. Sundaram's medical opinion (DX8, 19). The only rationale offered in support of this opinion is Dr. Sundaram's conclusory statement that pneumoconiosis is due to "prolonged exposure to coal dust." Furthermore, Dr. Sundaram (as well as the other physicians) relied upon a reported twenty years of exposure to coal dust, which I find excessive and unsupported by the evidence of record. Accordingly, I deny modification of the District Director's finding that Claimant's coal mine employment did not cause pneumoconiosis.

Total Disability

The final element a miner seeking federal black lung benefits must establish is that he is totally disabled due to pneumoconiosis. *See* 20 C.F.R. § 718.204. Again, because Claimant failed to establish the existence of pneumoconiosis, this inquiry is unnecessary. However, even if Claimant had established the presence of pneumoconiosis arising out of coal mine employment the evidence does not show that he is totally disabled due to pneumoconiosis. None of the validated pulmonary function tests or blood-gas studies contained in the record are qualifying under the disability standards set forth at 20 C.F.R., Part 718, Appendix B or C, respectively, and the medical evidence does not indicate cor pulmonale with right-sided congestive heart failure. *See* 20 C.F.R. § 718.204(b)(2)(i-iii). Dr. Sundaram provides the only medical opinion alleging that Claimant is totally disabled (DX8, 19, CX3). He concluded that Claimant did not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment based on Claimant's complaint of shortness of breath on limited activity, his reported work history, and a physical exam, chest x-ray, and pulmonary function test. As discussed above, I accord little weight to Dr. Sundaram's opinion because it is not well documented or reasoned and is based on an unsupported finding of pneumoconiosis, a reported

20 year history of coal mine employment which is excessive, and pulmonary function tests that were invalidated as unreliable by reviewing physicians. The remaining medical opinion evidence contained in the record establishes that Claimant is not totally disabled. Accordingly, I find Claimant has failed to establish this element and deny modification of the District Director's denial.

Conclusion

The newly submitted evidence, taken together with the previously submitted evidence, fails to establishes a change in condition or mistake in a determination of fact regarding the District Director's prior denial. In view of the above, Claimant is not entitled to benefits under the Act and applicable regulations. The claim must therefore be denied.

ORDER

IT IS HEREBY ORDERED that the claim of Donald Varney for black lung benefits under the Act be, and hereby is, **DENIED**.

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STEPHEN L. PURCELL
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Order may appeal it to the Benefits Review Board within 30 days from the date of this Order by filing a Notice of Appeal with the Benefits Review Board, P.O. Box 37601, Washington, D.C. 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Francis Perkins Building, Room N-2605, 200 Constitution Avenue, N.W. Washington, D.C. 20210.